MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** () Yes (x) No
Requestor's Name and Address RS Medical P O Box 872650 Vancouver, Washington 98687-2650	MDR Tracking No.: M4-03-9262-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address Pacific Employers Insurance Company Box 15	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: C290C0817476

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
01/10/03	**02/09/03**	**E1399**	**$250.00**	**$250.00**

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement, "We have provided product information and pricing documentation along with the prescription from the patient's doctor of record. We have included a copy of the carrier's explanation of benefits and our hcfas which show that total charges billed for the rental of the RS41 Sequential Stimulator do not exceed $500.00."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not respond to the dispute. Carrier's EOBs denied services as, "This procedure/supply must be preauthorized in accordance with TWCC rule 134.600."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Per TWCC 134.600 preauthorization is required when the rental of TENS unit exceeds a cumulative total is more than $500.00. The requestor only billed for $250.00 for a one month rental. Therefore, preauthorization is not required.

Therefore, based on this information additional reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

						Total Left Column:	$0.00
						Total Amount Due:	$250.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $250.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of the Order.

Ordered by:

	Michael Bucklin	12/27/04
Authorized Signature	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____